Barriers to Mental Health Care for Transgender and Gender-Nonconforming Adults: A Systematic Literature Review

Annie Snow, Julie Cerel, Diane N. Loeffler, and Chris Flaherty

Contemporary research suggests that transgender and gender-nonconforming (TGNC) adults encounter formidable barriers to health care, including access to quality therapeutic interventions. This systematic review is one of the first to specifically explore obstacles to TGNC mental health care. A rigorous literature review identified eight relevant studies: six qualitative designs and two quantitative designs. Thematic synthesis revealed three major barriers to care and five corresponding subthemes: (1) personal concerns, involving fear of being pathologized or stereotyped and an objection to common therapeutic practices; (2) incompetent mental health professionals, including those who are unknowledgeable, unnuanced, and unsupportive; and (3) affordability factors. Results indicate an acute need for practitioner training to ensure the psychological well-being of TGNC clients.

KEY WORDS: *barriers to mental health; mental health professionals; systematic review; transgender and gender-nonconforming adults*

In recent years, transgender and gender-nonconforming (TGNC) mental health care has evolved from an obscure topic of research to one of increasing popularity. As this inchoate body of literature continues to grow, so do opportunities for meta-analysis and systematic review. PROSPERO is currently host to nearly 100 TGNC-related protocols, many of which address psychological outcomes. The subject of TGNC mental health is particularly exigent considering the disproportionally high rate of mental health diagnoses for this population (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Su et al., 2016) and the alarming prevalence of suicide attempts among TGNC adults (Haas, Rodgers, & Herman, 2014).

Much has been written about TGNC experiences with general health care services (Bradford, Reisner, Honnold, & Xavier, 2013; Hughto, Rose, Panchankis, & Reisner, 2017), but less is known about this population's interaction with mental health amenities. Exploratory research published within the last decade suggests that TGNC individuals face formidable obstacles to therapeutic care. Moreover, the recently released *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (American Psychological Association, 2015) acknowledges the presence of these barriers. These challenges are unsurprising considering the historic pathologizing of TGNC identities and the controversial role therapists play as gatekeepers for gender-confirming surgeries (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016; Mizock & Lundquist, 2016).

In 2018, the World Health Organization declassified "transgender" as a mental health disorder, and the latest iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) no longer includes the diagnosis of gender identity disorder (American Psychiatric Association, 2013). Practitioners are beginning to accept that TGNC individuals present with the same mental health challenges as their cisgender counterparts, and these presenting issues, including depression and anxiety, may not be symptomatic of gender dysphoria (Meier & Labuski, 2013; Shipherd, Green, & Abramovitz, 2010). As increased understanding continues to remediate therapeutic practice, it is critical that mental health professionals (MHPs) intervene and destabilize barriers to care for this at-risk population. The following appraisal of the literature is one of the first to investigate obstacles to TGNC mental health care. Specifically, this review endeavors to address the question: What

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are the barriers to mental health care for TGNC adults?

LITERATURE SEARCH STRATEGY

Information Sources

We consulted the Preferred Reporting Items for Systematic Reviews and Meta-Analysis to conduct this review. From June to July 2018, we searched the following specialist databases: Academic Search Complete, CINAHL, PsycINFO, Web of Science, Scopus, Ovid-Embase, SWAB, and PubMed. The following search terms were used to refer to TGNC individuals: "transgender," "transsexual," "nonbinary," "genderqueer," "genderfluid," "gender nonconforming," "MTF," "FTM," "trans man," "trans woman," "male to female," and "female to male." The terms "counseling," "barriers to mental health treatment," "barriers to mental health care," "mental health care," and "mental and health treatment" were used to search for mental health–related literature. Search terms for all databases included at least one identifier for gender identity and one identifier for mental health.

Eligibility Criteria

We aimed for an inclusive search strategy to capture as much of the possible relevant literature; consequently, searches were not filtered by study design. Exclusion codes were modeled after a review on adult social care (Sutcliffe et al., 2012). Those codes include (a) language not English, (b) date published before 2008, (c) population not exclusively adults, (d) population not exclusively TGNC, (e) editorial or theoretical, (f) not on topic (for example, does not address barriers to mental health), and (g) wrong or specific intervention (for example, talking therapies). Studies that concentrated exclusively on gender identity counseling were excluded because the focus of this review is general mental health care. Literature that involved gay, lesbian, and bisexual subjects were also excluded. Although consolidated research of the lesbian, gay, bisexual, transgender, and queer population can be worthwhile, gender identity and sexual orientation are phenomenologically distinct, and essential differences may be lost when studying the two simultaneously (Worthen, 2013).

Study Selection

The initial search identified 1,195 papers that were reviewed for relevance (see Figure 1). After duplicate records were removed, 1,165 citations were screened based on title and abstract alone. Documents that met at least one of the exclusion criteria were removed, leaving 29 full-text articles to be assessed for eligibility. Of these remaining articles, 21 were excluded because they were theoretical (2), editorial (2), did not specifically address transgender populations (8), did not measure barriers to mental health care (5), or focused on a narrowly defined intervention strategy (4). Ultimately, eight papers were included in the review: six qualitative studies (Benson, 2013; Bess & Stabb, 2009; Ellis, Bailey, & McNeil, 2015; McCann, 2015; McCullough et al., 2017; Mizock & Lundquist, 2016) and two quantitative studies (Hunt, 2014; Shipherd et al., 2010). A demographic summary of the relevant literature is presented in Table 1.

RESULTS

Because the included studies are multidisciplinary, and given the inceptive nature of this research, thematic synthesis was used as the primary method of analysis (Boyatzis, 2009). Each study was meticulously coded as themes, identified as concepts appearing across the literature, materialized (Gough, Oliver, & Thomas, 2017). This systematic and inductive approach to the research revealed three major barriers to TGNC mental health care and five subthemes: (1) internal concerns, including fear of being stereotyped or pathologized (Benson, 2013; Ellis et al., 2015; Hunt, 2014) and objection to general therapeutic interventions (Hunt, 2014; Shipherd et al., 2010); (2) incompetent and unknowledgeable MHPs (Benson, 2013; Bess & Stabb, 2009; Ellis et al., 2015; Hunt, 2014; McCullough et al., 2017; Mizock & Lundquist, 2016), unnuanced MHPs (Ellis et al., 2015; Hunt, 2014; McCullough et al., 2017; Mizock & Lundquist, 2016), and unsupportive MHPs (Bess & Stabb, 2009; Ellis et al., 2015; Hunt, 2014; McCann, 2015; McCullough et al., 2017; Mizock & Lundquist, 2016); and (3) cost and affordability (Benson, 2013; Hunt, 2014; Shipherd et al., 2010). Included studies spanned three English-speaking countries: the United States, the United Kingdom, and Ireland. The results of the thematic synthesis are presented in Figure 2.

Personal Concerns

Fear of Being Stereotyped or Pathologized. At a micro level, personal concerns emerged as a salient

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Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses Diagram

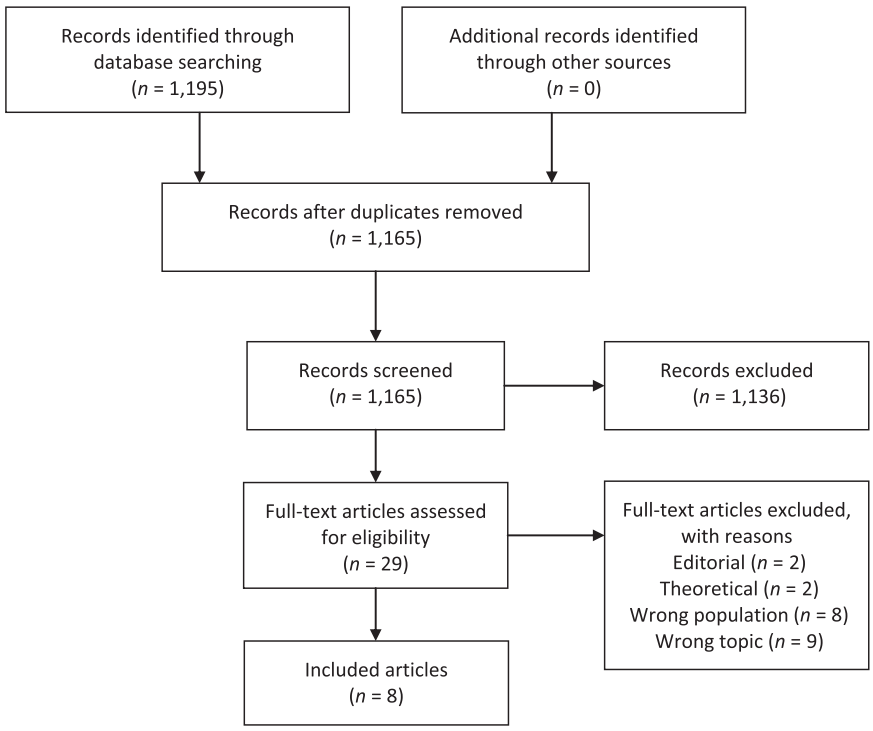
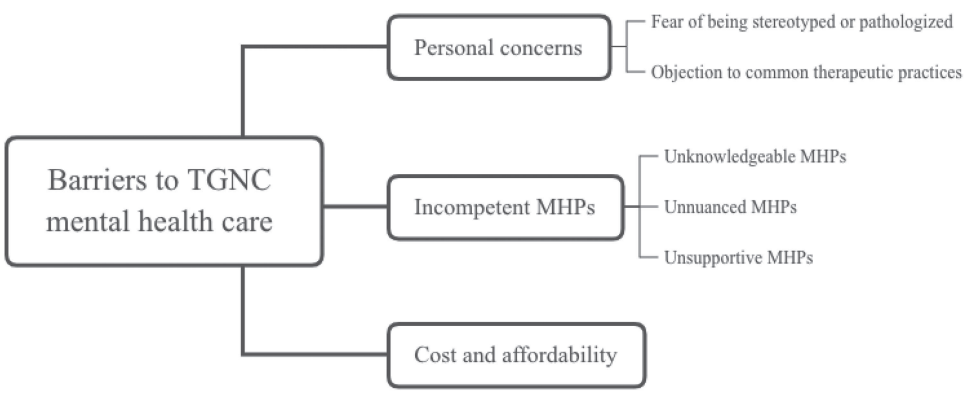


Figure 2: Results of Thematic Synthesis



Notes: TGNC = gender and gender-nonconforming; MHP = mental health professional.

barrier to TGNC mental health care. In three studies (Benson, 2013; Ellis et al., 2015; Hunt, 2014), participants expressed fear of being stereotyped or pathologized. In Hunt's (2014) study, participants indicated that they were afraid of judgment (33 percent, $n = 42$), prejudice, and discrimination (22 percent, $n = 28$). In Ellis et al.'s (2015) study, participants reported that being pathologized by practitioners was their biggest fear regarding mental health treatment. Participants in Benson's (2013) study indicated that being stereotyped and misunderstood was a principal concern—a fear that was bolstered by the belief that MHPs are unknowledgeable about trans issues.

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Table 1: Demographic Summary of the Included Literature

Study	*n*	Ethnicity/Nationality	Age (Years)	Gender	Region
Benson, 2013	7	86% European American 14% Latino	24-57	MtF, FtM	USA
Bess & Stabb, 2009	7	100% Caucasian	19-60	MtF, FtM, female, transsexual	USA
Ellis, Bailey, & McNeil, 2015	621	86% White British 8% Other White <7% Other ethnic groups	N/A	N/A	UK
Hunt, 2014	74	95% White British	16-70	Female, male, transwoman, transman, MtF transwoman, FtM transman, MtF transexual, FtM transexual, transgender, other	UK
McCann, 2015	4	75% Irish	28-54	MtF	Ireland
McCullough et al., 2017	13	31% White 31% Black/African American 31% Multiethnic 7% Latino	21-54	Male, MtF, FtM, Two-spirit, genderqueer, genderfluid, intersex	USA
Mizock & Lundquist, 2016	45	89% White 2.5% African American 2.5% Asian American 2.5% Latino American 2.5% Native American	21-71	Mtf, FtM, transman, transwoman, genderqueer, genderfluid	USA
Shipherd, Green, & Abramovitz, 2010	130	92% Anglo-Caucasian	22-79	FtM, MtF, F, transsexual	USA

Notes: MtF = male to female; FtM = female to male; F = female.

Objection to Common Therapeutic Practices. An objection to common therapeutic practices also surfaced as a significant barrier to TGNC mental health care. In their pioneering study, Shipherd et al. (2010) developed the Service Utilization Barriers Scale to measure internal, interpersonal, and systemic barriers to trans mental health care. The scale was administered to a general sample ($N = 130$) and to a subsample of individuals ($n = 68$) who reported mental health difficulty but did not seek treatment. For both groups, past bad experiences and a dislike of treatment aspects emerged as the top two barriers to mental health care. For the general sample, 22 percent reported not wanting to talk about their personal life, 22 percent reported not wanting to speak in groups, and 21 percent reported not wanting to be prescribed medication. For the subsample, 21 percent reported that they disliked talking to people about their personal life, 21 percent indicated that they did not want to be prescribed medication, and 18 percent revealed that they disliked speaking in groups (Shipherd et al., 2010). Hunt's (2014) study adds to Shipherd's findings, with 40 percent ($n = 52$) of participants reporting doubts about the efficacy of treatment.

Incompetent MHPs

Unknowledgeable MHPs. The aforementioned fears appear justified given the literature's most frequently occurring theme: incompetent MHPs. Seven of the eight studies reference this interpersonal barrier to mental health care, which includes ignorance about trans issues, an unnuanced approach to TGNC therapy, and transphobic attitudes and practices. In several studies, participants indicated that they had to educate their therapists about historical, political, cultural, and medical aspects of TGNC identity (Benson, 2013; McCullough et al., 2017; Mizock & Lundquist, 2016). Some participants suggested that this "psychotherapy barrier" (Mizock & Lundquist, 2016) was compounded by an incongruous financial burden: having to pay to educate their therapist (Benson, 2013).

Even when participants did not indicate pressure to educate their therapists, they often reported feeling misunderstood. According to Hunt's (2014)

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study, while the majority of the participants felt accepted by their counselor, only 45 percent felt either extremely (19 percent, $n = 24$) or very (26 percent, $n = 33$) understood. An absence of understanding led some participants to feel disrespected or mistrustful of their MHP (McCullough et al., 2017).

Unnuanced MHPs. In addition to being misunderstood, participants also indicated that practitioners focused too much or too little on their gender identity. This lack of nuance created substantial therapeutic barriers, especially for clients wanting to explore issues unrelated to their gender identity. According to Mizock and Lundquist (2016) multiple participants expressed irritation over their therapists' inflated focus on gender. As one participant related, "If I'm going to somebody for anxiety, all they want to talk about is how it must be because I'm trans, and how that must be the cause of all my problems, and that's very frustrating" (Mizock & Lundquist, 2016, p. 151). In Hunt's (2014) study, 4 percent ($n = 56$) of survey participants revealed that their mental health practitioner wanted to discuss gender identity issues in therapy, even if they had sought help for an extraneous concern.

Conversely, some study participants indicated that their mental health practitioner avoided gender identity altogether. Both Hunt (2014) and Mizock and Lundquist (2016) identified participants whose MHPs neglected the subject of gender identity, either because they had ruled it out as a presenting issue (Mizock & Lundquist, 2016) or because they had chosen to ignore it (Hunt, 2014). In both instances, the clients expressed dissatisfaction with their therapeutic experience.

Gender generalizing or intersectional insensitivity surfaced as another type of unnuanced behavior. According to Mizock and Lundquist (2016), gender generalizing occurs when psychotherapists "do not listen for, detect, and understand the unique experiences of gender among TGNC clients" (p. 152). Their MHP assuming that all TGNC experiences are the same or applying a "one size fits all" approach led some clients to disengage from therapy (Mizock & Lundquist, 2016). Similarly, therapists who maintained a binary construction of gender were deemed problematic by their TGNC clients (Ellis et al., 2015).

This failure to appreciate diversity was especially detrimental for clients holding multiple marginalized identities (McCullough et al., 2017). Black male TGNC participants related how onerous it was to find a therapist who understood the sociopolitical challenges of transitioning as a masculine person of color. One participant explained,

> Some people think they are open minded, like, oh, race doesn't really matter, like, I don't have a problem with race or something, but definitely when you are transitioning it is a big factor. . . . And I feel like even if I were to go to an African American counselor, I feel like, unless they were transgender, they would not totally understand it. . . . That's why I feel like sometimes you just have to split up your counselors. (McCullough et al., 2017, p. 430)

A participant in Mizock and Lundquist's (2016) study also indicated a need to consult multiple therapists to address all aspects of identity.

Unsupportive MHPs. The third and final subcategory of incompetence involves unsupportive and overtly transphobic MHPs. Although the majority 51 percent ($n = 66$) of respondents in Hunt's (2014) survey indicated that their therapist affirmed their gender identity, 23 percent ($n = 30$) reported that they did not feel affirmed. All 13 participants in McCullough et al.'s (2017) study reported that an MHP had invalidated their gender identity. Invalidation took the form of misgendering a client by not using correct pronouns, displaying visible discomfort when a client spoke about gender identity, and not supporting a client's decision to "come out" to family and friends (McCullough et al., 2017). Following the invalidating encounter, participants felt discouraged and were reticent to seek professional help again (McCullough et al., 2017).

Invalidation also took the form of pathologizing clients' TGNC identities (Bess & Stabb, 2009; McCann, 2015; McCullough et al., 2017; Mizock & Lundquist, 2016). Participants in Mizock and Lundquist's (2016) study spoke of their experiences with gender-reparative interventions in which psychotherapists treated their transgender identity as a disease to be cured. One participant explained, "A lot of [doctors and psychiatrists] seem to think that me being transgender is a mental health illness, and that's why I have all these problems" (Mizock & Lundquist, 2016, p. 152).

Other studies described respondents' encounters with hostile and abusive MHPs. A participant in

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McCann's (2015) interview disclosed that a therapist called her a "freak of nature" and "sexually immature" (p. 78). The client left the sessions thinking, "I am the lowest of the low" (McCann, 2015, p. 78). McCann (2015) also revealed that one participant was refused therapeutic services for identifying as transgender. Bess and Stabb (2009) reported equally hostile encounters in their study.

Cost and Affordability. In addition to the internal and interpersonal barriers to mental health care, three studies suggested the existence of a systematic barrier (Benson, 2013; Hunt 2014; Shipherd et al., 2010). The cost of mental health services proved to be a barrier for 31 percent ($n = 40$) of the respondents in Hunt's (2014) study, and affordability was the most frequently endorsed barrier to mental health care in Shipherd et al.'s (2010) survey. However, Shipherd et al. (2010) questioned this result, accentuating the fact that 95 percent of respondents had health insurance at the time of their study. The authors speculated that participants were unaware that insurance helped cover the cost of their mental health treatment, and they recommended that MHPs advertise their involvement in insurance panels to combat this misunderstanding (Shipherd et al., 2010). Finally, younger participants in Benson's (2013) study reported financial concerns; it is unclear whether these concerns relate to mental health treatment or transitional medical care.

DISCUSSION

This systematic review identifies three major barriers to TGNC mental health care and five corresponding subthemes. Personal concerns, including fear of being pathologized and an objection to therapeutic practices, comprise an internal obstacle to health care. This is not to imply that these personal concerns are idiosyncratic or unsubstantiated, because another barrier to TGNC mental health care involves unknowledgeable, unnuanced, and unsupportive MHPs: three distinct manifestations of incompetence. By far, this was the most commonly endorsed barrier to TGNC mental health care, suggesting that MHPs need more education and cultural understanding to facilitate rather than forestall treatment.

The final barrier to care was cost and affordability. Shipherd et al. (2010) challenged these results, however, referencing the fact that most of their participants were insured. It is also remarkable that participants in Hunt's (2014) UK study indicated that affordability was an obstacle given that mental health care is free to all British citizens under the National Health Service (NHS). Conceivably, these respondents preferred to see a private MHP, and indeed, Ellis et al.'s (2015) UK-based study revealed that TGNC clients favored private practitioners to NHS therapists. Ultimately, more research is needed to determine why TGNC clients perceive mental health care to be a costly endeavor and why some prefer to pay out of pocket for services that they may be able to procure for little to no expense.

Although this present review helps fill a crucial gap in the literature, being one of the first, it is limited by scarce, germinal research. Many of the included studies involved small sample sizes of mostly white, educated participants. Several studies also relied on nonrandomized purposive sampling, which is typical when studying a minority population (Meyer & Wilson, 2009). This study is also vulnerable to common biases involving systematic reviews, including outcome reporting bias, language bias, publication bias, and time-lag bias (Egger, Juni, Bartlett, Holenstein, & Sterne, 2003). In addition, although we took great pains to follow recommended coding protocols (Gough et al., 2017), there is always the potential for researcher bias. Notwithstanding these limitations, this review should serve as a catalyst for future transformative reviews on the subject, studies that seek to synthesize the experiences of TGNC individuals in an effort to improve their situation in society (Gough et al., 2017).

CONCLUSION

Preliminary research suggests that TGNC adults face an elevated likelihood of psychiatric distress and suicide attempts throughout their lifetime. According to one study, 44.0 percent of TGNC respondents reported a history of depression, 33.2 percent reported anxiety, and 40.1 percent reported overall psychological difficulty (Bockting et al., 2013). Furthermore, suicide attempts for this population are reported to be as high as 41 percent (Haas et al., 2014). Given the troubling prevalence of these general mental health outcomes, therapists and researchers alike must expeditiously identify and extenuate barriers to TGNC mental health care. To that end, this preliminary review exposes the presence of three recurring barriers. Although

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some obstacles may be more endemic than others, the incompetence of MHPs appears to be a common theme across time and space, and that should not be the case. Instead, as the field of TGNC mental health care continues to expand, so too must the knowledge and expertise of those entrusted with the psychological well-being of TGNC clients. This is especially true for social workers, who are bound by the NASW *Code of Ethics* to maintain competent practices, confront social injustice, and uphold the dignity and worth of all people. **HSW**

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